



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ROBERT HADEN
PO BOX 121589
ARLINGTON TX 76012

Respondent Name

TRAVELERS INDEMNITY CO OF CONN

Carrier's Austin Representative Box

Box Number 05

MFDR Tracking Number

M4-12-3481-01

MFDR Date Received

JULY 31, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Dr. Haden requests Medical Dispute Resolution in pursuant of Rule 133.305 Medical Dispute Resolution in the above referenced patient's case.

These services were requested and prescribed by the Division. The above referenced designated doctor performed the MMI examination and assigned the IR, but he did not perform the range motion, strength, or sensory testing of the musculoskeletal body area(s), that means he should be billing using the appropriate MMI CPT Code 99546 with the component modifier – 26. Reimbursement for the examining doctor is 80% of the MAR.

The physical therapist and/or health care provider other than the examining doctor that performs the range of motion strength, or sensory testing of the musculoskeletal body, the physical therapist and/or health care provider will bill with the component – TC. In this instance, reimbursement to the physical therapist and/or health care provider is 20% of the MAR."

Amount in Dispute: \$300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider's Request for Medical Fee Dispute Resolution involves reimbursement for a Designated Doctor evaluation. The Provider submitted billing for the services, which the Carrier denied as not timely submitted. After submitting request for reconsideration, the Provider submitted this Request for Medical Fee Dispute Resolution.

The Carrier has reviewed the Providers; submitted documentation. The documentation supports that the Provider timely submitted billing to the Carrier. Consequently, the Carrier is issuing reimbursement for the disputed services in accordance with the Texas Workers Compensation Act and Rules of the Division Worker's compensation."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 03, 2011	CPT Code 99456-W5-26 and 99456-W5-TC	\$300.00	\$110.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 amended to be effective May 31, 2012, *37 Texas Register* 3833, applicable to medical fee dispute resolution requests filed on or after June 1, 2012, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Texas Administrative Code §134.204 sets out the fee guideline for workers' compensation specific services on or after March 1, 2008.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated March 21, 2012

- 29 – The time limit for filing has expired

Issues

1. Is denial code 29 supported?
2. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
3. Is the requestor entitled to reimbursement for the disputed services under 28 Texas Administrative Code §134.204?

Findings

1. Carrie denied disputed service with denial code 29 – “The time limit for filing has expired”. Per Administrative Code 133.20 (a) The health care provider shall submit all medical bills to the insurance carrier except when billing the employer in accordance with subsection (j) of this section, (b) Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided. In accordance with subsection (c) of the statute, the health care provider shall submit the medical bill to the correct workers' compensation insurance carrier not later than the 95th day after the date the health care provider is notified of the health care provider's erroneous submission of the medical bill. A health care provider who submits a medical bill to the correct workers' compensation insurance carrier shall include a copy of the original medical bill submitted, a copy of the explanation of benefits (EOB) if available, and sufficient documentation to support why one or more of the exceptions for untimely submission of a medical bill under §408.0272 should be applied. The medical bill submitted by the health care provider to the correct workers' compensation insurance carrier is subject to the billing, review, and dispute processes established by Chapter 133, including §133.307(c)(2)(A) - (H) of this title (relating to MDR of Fee Disputes), which establishes the generally acceptable standards for documentation.

The denial code is not supported as the provider has submitted documentation supporting the bills were submitted in a timely manner.

2. Requestor billed with CPT Code 99456-W5-26 in the amount of \$950.00 with 3 units for a Maximum Medical Impairment (MMI) and Impairment Rating (IR)

Per Administrative Code (j) Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows, (1) The total MAR for an MMI/IR examination shall be equal to the MMI evaluation reimbursement plus the reimbursement for the body area(s) evaluated for the assignment of an IR. The MMI/IR examination shall include, (3) The following applies for billing and reimbursement of an MMI evaluation, (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456.

Reimbursement shall be \$350, (4) The following applies for billing and reimbursement of an IR evaluation, (A) The HCP shall include billing components of the IR evaluation with the applicable MMI evaluation CPT code.

The number of body areas rated shall be indicated in the units column of the billing form, (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas, (i) Musculoskeletal body areas are defined as follows, (II) upper extremities and hands; and, (III) lower extremities (including feet), (ii) The MAR for musculoskeletal body areas shall be as follows, .

Review of the submitted (II) If full physical evaluation, with range of motion, is performed, (-a-) \$300 for the first musculoskeletal body area; and, (-b-) \$150 for each additional musculoskeletal body area, (iv) If, in accordance with §130.1 of this title (relating to Certification of Maximum Medical Improvement and Evaluation

of Permanent Impairment), the examining doctor performs the MMI examination and assigns the IR, but does not perform the range of motion, sensory, or strength testing of the musculoskeletal body area(s), then the examining doctor shall bill using the appropriate MMI CPT code with CPT modifier "26." Reimbursement shall be 80 percent of the total MAR.

Therefore, CPT Code 99456-W5-26 is supported.

The total MAR is \$760.00

Per 28 Texas Administrative Code §134.204 (j) Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows, (3) The following applies for billing and reimbursement of an MMI evaluation, (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be \$350, (4) The following applies for billing and reimbursement of an IR evaluation, (ii) The MAR for musculoskeletal body areas shall be as follows, (II) If full physical evaluation, with range of motion, is performed, (-a-) \$300 for the first musculoskeletal body area; (-b-) \$150 for each additional musculoskeletal body area and (v) If a HCP, other than the examining doctor, performs the range of motion, sensory, or strength testing of the musculoskeletal body area(s), then the HCP shall bill using the appropriate MMI CPT code with modifier "TC." In accordance with §130.1 of this title, the HCP must be certified. Reimbursement shall be 20 percent of the total MAR.

Per medical documentation provided CPT Code 99456-W5-TC is not supported as documentation shows a certified technician performed the range of motion for the body areas assigned, not the examining doctor. Therefore, CPT Code 99456-W5-TC reimbursement is not allowed.

3. The respondent issued payment in the amount of \$650.00 for CPT Code 99456-W5-26. Based upon the documentation submitted, additional reimbursement in the amount of \$110.00 is recommended for CPT Code 99456-W5-26.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$110.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

9/27/13

Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.